Y4. F49: H34/9
94-2

94th Congress
2d Session

COMMITTEE PRINT

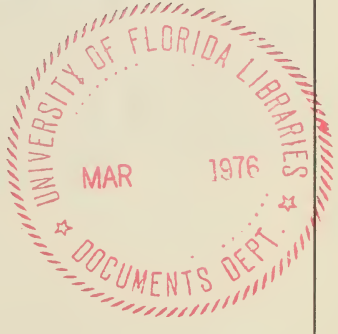
Cost and Utilization Control Mechanisms in Several European Health Care Systems

Report by the Staff to the

COMMITTEE ON FINANCE
UNITED STATES SENATE

Russell B. Long, Chairman

FEBRUARY 1976



Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
64-731 WASHINGTON : 1976

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price 35 cents

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PREFACE

Many books and articles have been written describing the health care financing systems in various European countries. It was neither the assigned task nor the staff's intent to produce yet another description or summary of European health delivery systems. Rather, the intent was to take a more focused look at some specific aspects of a few European health care financing systems in areas of common concern.

Perhaps the major problem faced by the Congress in dealing with governmental health care financing in the United States, is the problem of structuring appropriate, equitable and workable cost and quality control mechanisms. The intent of the staff visit was to learn as much as possible in a relatively brief period of time about the cost and quality control provisions in selected European financing systems. We certainly do not pretend to have become expert in this period of time on these aspects of those systems, nor do we intend in any way to pass judgment upon steps taken or not taken in the various countries visited.

A word about the countries visited. The staff was requested to visit England and West Germany because the Chairman and Senator Ribicoff were to be in those countries and were interested in learning more about the health financing systems in the countries they visited. The Netherlands was added to the itinerary primarily because a number of knowledgeable previous visitors from the United States advised that the Dutch system contained features worthy of study.

The first section of this report consists of a brief overview of certain salient characteristics of the health care financing systems in West Germany, the Netherlands and England. We do not outline all features of those systems in detail as the material is readily available elsewhere. The body of the report consists of observations with respect to each country in three subject areas: Hospital Reimbursement, Physician Reimbursement, and Utilization and Quality Control.

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Finance Committee Staff Report on Cost and Utilization Control Mechanisms in Several European Health Care Systems

INTRODUCTION

During the month of August, 1975 Mr. Jay Constantine and Dr. James Mongan of the Finance Committee staff visited several European countries in conjunction with the visit to Europe of Senators Long and Ribicoff. The primary mission of the Senators' visit was to study the international economic situation. However, due to the fact that the Finance Committee has jurisdiction over Medicare and Medicaid and any future National Health Insurance programs, the Senators believed it would be valuable for them, in conjunction with their visit, to arrange a few brief meetings with people experienced with health financing programs, while in Europe, so as to gain information with respect to the European health care financing programs.

Recognizing that the time which they could devote to the study of European health systems on this visit was limited, the Senators asked Mr. Constantine and Dr. Mongan to arrange these brief meetings and, also, to spend additional time in selected countries, visiting with appropriate health care officials seeking further background information which might prove of value in the Committee's ongoing work with respect to the U.S. health care programs. What follows is a report of the staff visit.

INDIVIDUALS AND ORGANIZATIONS VISITED BY STAFF

Germany—August 13–15, 1975

Ministerialrat Harsdorf, Regierungsdirektorin Schneider, and Dr. Bernd Liese—Bundesministerium fuer Jugend, Familie und Gesundheit.

Ltd. Ministerialrat Gottfried Friedrich, Ministerium fuer Arbeit, Gesundheit and Soziales.

Professor Dr. Hans-Werner Mueller, Deutsche Krankenhausgesellschaft.

Dr. Odenback, et al.—Bundesaerztekammer, Koeln, Haedenkampstr.

Dr. Adolf Frhr. Von Haaren, Director, Evangelisches Krankenhaus.

Frau Merte Bosch, Geschaftsfuhrer Im, Verbank Der Arzte Deutschlands.

Netherlands—August 18, 1975

W. B. Gerritsen M.D., et al., Director-general, Ministry of Public and Environmental Health.

J. Dipersloot, M.D., Secretary-general, Royal Dutch Medical Association, Albert van der Werff, M.D., and J. C. M. Hattinga Verschure, M.D.

England—August 19–22, 1975

Dr. Forbes and Mr. Weeple, Department of Health and Social Security.

John Winn Owen, et al., Administrator, St. Thomas Hospital.

Geoffrey Phalp, Secretary, King Edward's Hospital Fund for London.

Gordon McClachen, Nuffield Provincial Hospitals Trust.

Oliver J. Rowell, General Manager, Nuffield Nursing Homes Trust.

OVERVIEW

1. Perhaps most important, from the perspective of this report, is the fact that, as in the United States, health costs are rising at rates faster than the general cost-of-living in each of the three countries we visited. This basic fact is as much a matter of serious concern in each of those countries as it is in the United States. Additionally, the disproportionate rates of increase in health costs is leading—in all of the countries visited—to intensive discussion among those charged with formulating health policy of various means of controlling the costs and utilization of health services.

This issue assumes added importance at a time when the gross national products of the countries are failing to grow as rapidly, and on as sustained a basis, as in the past.

2. In general, each of the countries visited seems to have gone further than we have in the United States with respect to applying Governmental controls over the unit costs of hospital and medical services. For example, where physicians are paid on a fee-for-service basis, a fee schedule with specified allowances is generally utilized; and, in the area of hospital reimbursement, prospective per diem payment is generally employed in contrast to the retrospective cost-based method of payment usual in this country.

In addition, each of the countries visited has gone further than the United States with respect to the imposition of controls on hospital capital expenditures. Unlike the situation in the United States where capital costs are included as a part of reimbursement formulas (in the form of depreciation and interest on debt), in these European countries capital costs are considered separately from the general hospital reimbursement mechanism.

In the area of utilization and quality controls, the countries visited appear to have taken a different path than has the United States. In each of the countries the necessity of a hospital admission is scrutinized in nearly every case by at least two physicians since, in general, a non-hospital based physician refers a patient for admittance and the admission is actually authorized by a hospital-based physician. Beyond this "structural" review of the necessity of admissions, there

is little formal utilization review activity. However, in each country, there was substantial interest in establishing more effective review mechanisms. In this regard, we were questioned extensively concerning the Professional Standards Review Legislation currently being implemented in the United States.

3. Hospitals in the countries we visited tend to differ from hospitals in the United States, in that they deliver, in addition to acute care, more long-term care than is ordinarily rendered in American hospitals. This general fact is reflected statistically. The average length of stay in hospitals in Europe is considerably longer than in United States hospitals. There are a number of reasons for these longer lengths of stay including a lack of sufficient long-term care beds outside of hospitals and different cultural mores, such as the expectation that maternity stays should average 10 or 11 days. Another statistic illustrating different patterns in European hospitals concerns staffing ratios. Roughly, the hospitals in West Germany have a ratio of one employee for each bed, in the Netherlands 1.5 employees per bed and in England 2 employees per bed, whereas in the United States, the national ratio is well over three employees per bed. The extent to which these personnel ratios reflect the difference in patients served and the extent to which they reflect superior efficiency in the European hospitals is a matter worthy of further study.

4. The West German health financing system is based upon a social insurance model in which numerous sick funds, financed by employer and employee contributions, reimburse for hospital and physician services. Hospitals are generally reimbursed on a prospective rate basis modified by a series of retrospective adjustments. Generally, the hospitals, all of which are non-profit, are owned and operated by local governmental units and religious institutions rather than the German Federal or State governments.

Physicians in West Germany are either salaried employees of hospitals or else work outside of hospitals on a fee-for-service payment basis. Out of hospital physicians generally do not have the right to treat their patients in a hospital.

As the above outline indicates, the West German health system bears some similarities to our own—the sick funds are somewhat analogous to our Blue Cross or private health insurance plans, many physicians are paid on a fee-for-service basis, and the majority of hospitals are not governmentally owned or operated.

5. Each of the above general statements with respect to the West German health financing system holds generally for the system in the Netherlands; thus the Dutch system is also similar to our system in the United States. One major difference between the West German and Dutch systems is that in West Germany the level of government primarily responsible for health financing is the State whereas, in the Netherlands, the system is a national system. Another difference is that the social insurance funds in the Netherlands cover only about 70 percent of the population, while the remaining 30 percent (generally upper income) are privately insured. Yet another difference is that Dutch hospitals provide a substantial amount of out-patient care in contrast to West German hospitals where such care is almost non-existent.

6. In Britain the health financing system is markedly different from the system which we have in the United States. Rather than being an insurance-based system, the British Government operates a national health service, based upon a total budget,[1] funded largely out of general revenues, which is responsible for providing health care to all citizens without respect to insured status.

As a consequence of this fundamental difference, hospitals are operated on an annual overall budget directly by governmental bodies rather than being reimbursed under any kind of prospective or retrospective per diem formula. Similarly, in hospital physicians are generally salaried employees of the health service. Outside of the hospital, general practitioners are ordinarily compensated on a fixed capitation basis.

Because of the fundamental difference between the British system and our own, few individual elements of the British system would seem to be transferable to the United States. For example, there is little to be learned in Britain on mechanisms of controlling fee-for-service payment to physicians since the overwhelming proportion of British physicians are not paid on a fee-for-service basis.

The above is in no way intended to pass judgment upon the British system, but merely to state that the technical and philosophic problems which they face in controlling health costs, due to the nature of their system, are in large part different from those problems which we face.

HOSPITAL REIMBURSEMENT

West Germany.—Generally, hospitals in West Germany are reimbursed according to a negotiated prospective per diem rate. The rates are negotiated between the sick funds and the hospitals in an area, with the State government mediating the negotiations. The negotiations are generally based upon an examination of the costs involved in providing care and while a hospital classification system is used, it basically takes only bed size into account. The hospitals are not required to prepare specific detailed yearly budgets although, in a sense, such budgets are necessary since hospitals can apply for retrospective rate adjustments which must be justified by budgetary figures. The laws calling for prospective cost-based reimbursement are relatively new and, prior to 1974, reimbursement was apparently not as tightly controlled, with yearly deficits merely being subsidized by local governmental units. A hospital enjoying a surplus of revenues as a result of the prospective rate generally receives a reduced rate in the following year. This does not appear to offer much incentive to hospitals to have unexpended funds at the end of a year.

Representatives of the West German Hospital Association pointed out to us that one effect of the new law calling for the establishment of prospective rates has been to further focus public attention and concern on hospital per diem costs. They also made the point that an improved and more sophisticated hospital classification system would be desirable in negotiating the prospective rates.

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[1] The total budget approach to all health care provided under the National Health Service provides interesting and signficant contrast with the line item budget approach in the United States. In Great Britain the lack of identifiable items allocable to specific health areas and activities has the effect, among others, of inhibiting the ability of the various health care interests to advocate increases or other changes in their specific areas of concern.

Reimbursement for hospitals' capital expenditures is handled separately from the prospective hospital operating costs reimbursement system. Basically, each State has a pool of capital funds and decisions on the allocation of these funds are made under a State plan for hospital construction. Generally, in most areas of West Germany, the stated public policy is not to build additional hospital beds but, rather, to apply capital to the modernization or conversion of existing hospital beds. The West Germans face problems similar to those in the United States and Canada in seeking to close down excess bed capacity in small hospitals in more sparsely populated areas. There, local political pressures—including community pride and the hospital as an employer—inhibit control efforts. In instances, the problem is resolved via compromise such as conversion of the hospital to what would be a skilled nursing home here.

Again, the system for the distribution of hospital capital funds is relatively new and some representatives of West German medical organizations pointed out that they felt there may be too many political influences in the capital allocation process. These representatives went on to say that, although, theoretically the State plan for capital expenditures would address and control the building of various specialty units, that control is still somewhat theoretical and not entirely effective.

Netherlands.—Again, in the Netherlands, hospitals are basically reimbursed according to a prospective rate based upon the cost of providing care. Again, hospitals are classified for purposes of establishing the rate, but only by bed size.

Hospitals must prepare budgets and the budget is compared against established national guidelines which contain, for example, highly detailed and specific indexes of the number of hospital personnel allowed per patient day and the costs acceptable based upon the training and experience of each of the various personnel. These guidelines are available to hospital administrators and the administrators are, therefore, aware of the limits placed upon them as they operate through the year.

With respect to capital reimbursement, there is a general policy in the Netherlands that no new hospitals may be built. In addition to this, hospitals must seek Government permission to rebuild, and the Government sets acceptable figures for the number of beds to be rebuilt and the acceptable capital cost per bed. Capital is then generally obtained privately and the Government pays a depreciation amount. The Government has established planning criteria for the number of beds which ideally would be available in each area of the country.

Britain.—In Britain, national health service hospitals basically receive, through allocation by the central government to regions, a lump sum budget amount based upon costs during the prior year, plus an additional allowance for inflation and, perhaps changes in services. The budget is examined with general focus on the margin of increase over the previous year. The budget may be altered due to a change in circumstances (such as general salary increases) ; so, in a sense, the budget ceiling is not really an upper limit on expenditures. However, leaving aside obvious factors such as salary increases, hospital administrations which consistently fail to meet their budgets may be replaced.

Capital expenditures are handled through a separate pool of health service funds with small capital improvements being funded by a regional fund and large building projects being handled at the national level.

General Discussion.—As the above paragraphs indicate, each of the countries visited seems to have gone beyond the system in our country where hospitals are generally reimbursed for their reasonable costs on a retrospective basis under Medicare, Medicaid and Blue Cross, and on a charge basis under private health insurance, and where capital associated costs are generally included within the overall per diem charge. There has, however, been action at the State level in many States toward establishing a rate-setting process so as to bring elements of prospective reimbursement into our system. Additionally, there has been some movement toward a prospective payment mechanism under Medicare in the form of a number of demonstration programs.

On the capital expenditures side, local health planning agencies have been established in the United States which are charged with reviewing the necessity of capital expenditures; more recently, States have been mandated to establish certain certification of need programs which, in a sense, will have final authority over deciding whether a given hospital can make substantial capital expenditures. Thus far, we have not separated capital expenditures from general hospital reimbursement, and we have not established statewide pools of capital.

PHYSICIAN REIMBURSEMENT

West Germany.—Roughly 50 percent of the physicians in West Germany are full-time salaried employees of hospitals (although a number of these physicians do maintain fee-for-service private practice in their free time). The remaining 50 percent—a large proportion of whom are general practitioners—practice out-of-hospital and are reimbursed on a fee-for-service basis. It is the reimbursement of this latter group which was of most interest to us. Basically, each of the many sick funds annually negotiates an amount of money which will be available for physicians' fees in an area with the sick fund physicians association. The sick fund physicians construct a type of fee schedule or relative value scale to divide the funds among physicians in an area. Different social insurance funds may have different fee schedules but the differences are generally minor. Though negotiations are held annually on the funds available for physician fees apparently both parties assume at the beginning of the negotiations that increases in funds will be generally linked to any general inflation in the economy. Consequently, these negotiations apparently rarely lead to bitter disputes. The physicians association generally makes only minor changes in fees among specific procedures. The fee schedules do not contain any rural-urban payment differential although rural physicians often receive bonuses and income guarantees from the community. Similarly, with respect to specific services and procedures, the fee schedules do not contain differentials in payments to specialists as opposed to general practitioners. However, there are numerous specialized procedures for which general practitioners will not be reimbursed.

Netherlands.—In the Netherlands about one-half of the practicing physicians are general practitioners. These general practitioners are paid on a capitation basis for the roughly 70 percent of patients who are covered by the sick funds. For the remaining 30 percent of patients who are covered by private insurance, general practitioners are paid on a fee-for-service basis. The other 50 percent of practicing physicians are specialists who are reimbursed by both the sick funds and private health insurance on a fee-for-service basis. Again, as in West Germany, fees are negotiated annually by the boards of the sick funds and private insurance companies and the physicians' organizations. In the case of the social insurance funds, negotiated changes may be vetoed by the Health Minister and a new rate set, although this authority has never been exercised. With respect to the fees negotiated by the private insurors, approval of the Economic Minister is required and again is generally granted. It may be assumed that the authority of the Health and Economics Ministers to disapprove results of these negotiations, while not in fact exercised, do explicitly influence the negotiators during the course of their work. The fees negotiated by the private insurors are generally linked to the fee negotiated by the social insurance fund, though they are somewhat higher. The gap between the private and public fees has narrowed in recent years. Also, as in West Germany, the annual negotiations generally result in an across-the-board percentage increase closely linked to the general increase in the cost of living. Urban, rural, or specialty fee differentials are not general.

Great Britain.—In Britain the vast majority of physicians are reimbursed for most of their professional efforts on a salaried or capitated basis through the national health service. We did not explore in detail how these salaries or capitation rates are established or their reasonableness.

General Discussion.—Both countries visited which employed the fee-for-service reimbursement mechanism in a broad sense—West Germany and the Netherlands—have gone beyond any steps taken in the United States with respect to controlling individual physicians' fees. These countries utilize an annually negotiated fee schedule. In the United States, the Medicare, many Medicaid programs, and most private insurance plans, have since enactment of Medicare, sharply departed from the use of fee schedules which had, previous to Medicare, been prevalent under basic Blue Shield and private health insurance. Instead, during the past ten years, reimbursement of doctors has been related to the concept of paying a doctor's customary charge up to a limit represented by the prevailing physicians' charges for that service in the locality. Generally, in both the private and public sectors of the United States, there have been few effective limitations on the extent to which these customary and prevailing charges could be increased from year to year. A recent Medicare amendment does, however, seek to limit acceptable increases in prevailing physicians' charges from year to year. The statutory limitation relates allowable increases to changes in the costs of practice and earnings levels in an area.

Aside from the stricter limitation on fees in Germany and the Netherlands, the use of a fee schedule also results in generally uniform reimbursement for a specific service in those countries whereas, in the

United States, the variation between the prevailing charges from one area to another and between specialists and nonspecialists can be quite striking.

It should be noted that none of these reimbursement limitations—negotiated or otherwise—adjust for general changes in the mix or frequency of given medical services from year-to-year. The cost of such changes may equal or exceed the impact of economic index changes.

An impressive conclusion from our discussions in West Germany and the Netherlands was the reasonably rational nature of the relationship and continuing dialogue between physicians, government, and other third parties. Obviously, strongly held views obtain but we would characterize the relationships between the parties as much more harmonious than acrimonious.

HOSPITAL AND PHYSICIAN UTILIZATION CONTROLS

West Germany.—Aside from the previously mentioned fact that almost all hospital admissions occur after the patient has been seen by two physicians—his own physician and the hospital physician—there is little formal utilization review in German hospitals. A number of the hospitals have review committees of one sort or another, but we were told that these were not considered particularly effective. In addition, the social insurance funds monitor hospital utilization but with little intervention.

In the case of ambulatory services provided by physicians, the social insurance funds do maintain overall statistical figures with respect to various physicians. However, review is minimal and is generally limited to those cases where a physician's practice—usually based upon financial volume—appears grossly out of line with that of his colleagues. The best estimate we could get was that less than 1 percent of claims are questioned with respect to possible inappropriate utilization.

Netherlands.—In the Netherlands, as in West Germany, most patients are seen by two physicians before being hospitalized. Again, as in West Germany, beyond this there is little utilization review. There is a theoretical mechanism for utilization review through the employment of control or review physicians by the social insurance funds but, in general, we were told that this review is pro forma. The Dutch, however, are beginning to develop aggregate statistical data on utilization in various hospitals in an attempt to strengthen their review activities.

With respect to ambulatory services provided by physicians, there is also little actual review, although the social insurance control physician mechanism exists here also. In the outpatient area also, the Dutch are beginning to maintain statistical data which they believe will allow more effective review.

Great Britain.—As with some of the reimbursement issues discussed above, many questions on utilization review are not really pertinent to the British system. Questions of quality review are relevant there, as in any other country but, focusing on the issue of utilization control alone, there would be little reason in a system such as the British system to develop complex review mechanisms since the financial incentive for both the physician and the hospital is, if anything, to

underutilize rather than overutilize. Consequently, there has been little pressure for the development of utilization review activities.

General Discussion.—It would appear that, generally, in the two countries we visited—West Germany and the Netherlands—where questions about utilization control and review activities were applicable, these activities were not highly developed. The basic mechanism for justifying a hospital admission was the admitting hospital staff physician. Beyond this, there was little formal review.

In the United States the situation is somewhat different. In this country there is no similar sharp division between hospital physicians and out-of-hospital physicians—rather, physicians care for their patients while they are hospitalized and while they are out of the hospital. This feature of the United States health care system is probably advantageous and, in fact, we found efforts in each of the countries visited to improve the continuity of patient care rather than have patients split among physicians.

In the United States, hospital admissions have not traditionally been subject to automatic review by other physicians. We have, however, had in this country hospital utilization review committees which have operated with varying degrees of effectiveness. Recent legislation authorized the establishment of Professional Standards Review Organizations composed of physicians in each area, who are charged with reviewing the utilization and quality of services provided. Although not fully implemented, these organizations would appear to be more substantial, where they function, than the rudimentary review committees which exist in the countries visited.

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